Biocitizenship and forced removals

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There are researchers, including in the global health sphere, who have an interest in how lack or loss of power gets into the body and causes physical illness and mental anguish.

Farmer (and others) have looked at questions of citizenship, power, and rights in the context of colonialism, a telling and far-reaching example of such disempowerment. They

embrace the notion of biocitizenship—a concept that considers the ways access to limited social goods mediates the relationship between citizens and state, and helps define who "belongs" (as citizen) and who does not. This notion of biocitizenship provides a useful lens to interrogate how forced removals of established families and communities affect well-being.

A report from May 2018 by the think-tank Oakland Institute describes the burning of homes and uprooting of tens of thousands of Masai in Tanzania to make way for foreign-owned tourism development. Studies by the International Consortium of Investigative Journalists (ICIJ) show that the World Bank, sometimes failing to adhere to its own guidelines, funds projects that uproot communities—more than 3 million people over a 10 year period. Some forced removals harken back to colonial and post-colonial periods—for example, the resettlement of millions of Tanzanians in the 1960s and 1970s into 2500 villages, the uprooting of 1.2 million Kenyans, 2.5 million Algerians (1952-63) or millions of people from District 6 in apartheid South Africa (1960-83). These tragedies typically present as humanitarian crises and victims consistently speak of extreme anxiety, sadness, and anger.

A striking example of a forced removal policy which has drawn international attention is the still evolving British political crisis known as the Windrush scandal. In 2010, in response to rising levels of nativism, the British Home Office launched its draconian immigration campaign which became known in 2012 as its "hostile environment" policy. Designed to reduce the number of illegal immigrants, it forced landlords, employers, banks and NHS services to run immigration status checks on those, in effect, "who looked like or sounded like immigrants". The 2016 Immigration Act gave landlords the right to evict tenants who could not prove their citizenship. Caught up in this initiative were citizens known as the Windrush generation, immigrants from the Caribbean (and elsewhere) who had arrived between 1948 and 1971 and given leave to remain in 1971. Because they often lacked official documentation and the Home Office had destroyed their stored landing cards in 2010, they had difficulty proving their legal status. Thousands were deported or threatened with deportation, many lost access to social goods and employment and most suffered anxiety**.** Unconscionably, the government knew of these injustices as early as 2013 and ignored them.

The destruction of Windrush landing cards (despite clear warnings they were vital to establishing legal status) seems to symbolize loss of biocitizenship. Indeed, a multitude of recorded interviews of Windrush victims show the impact of lost access to healthcare and other social goods as well as a sense of alienation, "unbelonging", betrayal and anguish associated with separation from family. For some, these losses would evoke a life as a colonial subject, living without status or agency, without biocitizenship, in a region where race-based access to health and social services was a key incentive for independence .

With its "hostile environment", the British Home Office has linked current policy with its colonial past, parts of which officialdom had made every effort to suppress. Like most European colonial history, it is top-down, incomplete and therefore inaccurate. Archived

material consists almost exclusively of military and administrative documentation, absent the voices of ordinary persons. It is selective: the destruction, disappearance, or ferreting away of embarrassing or unwanted colonial records is not unusual. What the Home Office has managed to resurrect and bring to the fore is a Caribbean history, one based on slavery (the importation of 1.6 million slaves)—egregious, profound exploitation across centuries. Only an extraordinary lack of mindfulness of the past and preoccupation with satisfying nativist sentiments could allow this to happen.

The Windrush scandal is now part of colonial history that historians report they want to write from the inside out, as a "history of emotion". They have begun to focus on the "hostile environment" policy as one explicitly aimed at creating anxiety among immigrant populations. They will focus on those of the Windrush generation that were presented with NHS bills, refused social assistance, evicted from their homes, refused re-entry into the country; on families surprised by their loss of power, right, and citizenship. Inevitably, historians will link the promotion of nativist sentiments beginning in 2010 to the anti-immigration rhetoric and rise of nationalism and will conclude both were ill-judged and shameful.

Pandemic response: fear is inevitable, panic is optional

- 28th Mar 2018

Caring for influenza victims, 1919 - Red Cross

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Research shows that when bad things happen, rational thought and communication typically give way to the irrational; we seem hardwired to blame others and sometimes assign intentionality. When the 1918 influenza

pandemic spread to a world at war, belligerent nations quickly blamed one another, citing squalid trenches, overcrowded medical camps, unhygienic troop transport and staging posts—factors that often applied as much to the accusers as the accused. At the local level, the enemy within was often blamed—spies, immigrants, migrant workers, or simply those identified by their otherness. 100 years later, has anything changed?

In reality, the overlay of many factors fuelled the 1918 pandemic, including its timing (with the war), the particular susceptibility of young adults (of soldiering age) to the virus, prolonged comingling at close quarters, damp germ-infested environments, and indeed, the arcing transport networks between continents and countries. Data maps and visualisations of the pandemic help show its multiple and interconnected pathways and how it circumnavigated the globe five times in 18 months, killing an estimated 50 million people.

In 1918, many countries responded to the pandemic by censoring news, the aim of which was to avoid demoralising the population in a time of war. Instead of adequate, transparent, and targeted communication with the public and the institution of health measures, government officials in many (but not all) cases denied or understated the pandemic and provided the public with false reassurances—repeated refrains being "there is no cause for alarm" or "fear kills more than the disease". The disconnect between these messages and the sight, for example, of horse-drawn carts collecting corpses off city streets (the death in Philadelphia of 786 in one day and 12,000 in 6 weeks) was to transform an epidemic of fear into one of terror and panic. According to the Red Cross, it evoked images of the Black Death in the Middle Ages.

Three decades ago, Jonathan Mann described the HIV/AIDS crisis as consisting of two epidemics, the epidemic itself and reaction to it (the second of these being characterised by the displacement of evidence and science-based communication by fear and blame). The 1918 influenza pandemic has lessons to offer on both "epidemics", including (or especially) those where the epidemic is overstated or in some cases non-existent—ie, where the contagion is principally fear or panic. For instance, after an outbreak of "swine flu" in 1976 at Fort Dix, USA, the National Immunization Program was launched, aiming to vaccinate "every man woman and child" (according to the US President then running for re-election). The National Immunization Program was seen as being motivated by politics rather than science and not directed by "effective communication from scientifically qualified persons"—the result of which was to engulf the nation in fear. After 40 million Americans had been immunised, no cases discovered outside of Fort Dix, and only one death and 13 hospitalisations, the National Immunization Program was abandoned and declared a debacle.

In similar fashion, the Ebola pandemic (2014) caused panic across the globe. In the USA, public health officials found themselves confronting not a disease epidemic (it had only seen four cases and one death compared to more than 11,000 deaths in west Africa), but rather a fear contagion that led to hysteria. Parts of the US media's reach outwards to cast blame (on African governments, health agencies, care providers, and even victims) simultaneously reached inwards to stoke fear. Again, risk and communication analysis shows that what was needed yet lacking was robust and "comprehensive, transparent and easy-to-understand information on risks and the current degree of scientific uncertainty".

In between swine flu and Ebola was of course severe acute respiratory syndrome (SARS) in 2003, which caused a wave of irrational responses, fear spreading faster than the disease itself, devastating trade, travel, and tourism in a host of countries. It led to the development of the International Health Regulations (IHR), first tested by the H1N1 pandemic in 2009 that also led to panic and mass hysteria in many countries. Although WHO explicitly sought to avoid fear panic by taking measured responses, in some ways it fuelled anxiety. Evaluation of its response shows that it did not "acknowledge legitimate criticisms, such as inconsistent descriptions of the meaning of a pandemic"; after it declared a pandemic, a time when public awareness was particularly important, WHO "chose to diminish proactive communication with the media by discontinuing routine press conferences on the pandemic". Other communication failures included confusion over what could happen with what was most likely to happen.

Over the last 100 years, the global community has been relatively fortunate: SARS for example was an "easy problem to solve. Once clinical symptoms appear then there is ample time to isolate someone before they become infectious". Similarly, H1N1 was relatively a mild virus. Today, however, a highly urbanised, globalised community is facing more frequent and more deadly viruses. For the Coalition for Epidemic Preparation Innovation (CEPI), backed by the US Centers for Disease Control and Prevention and the Bill and Melinda Gates Foundation, the worry is that viruses such as H7N9 will mutate to become transmissible from human to human. CEPI's repeated warning is that we react and don't plan. The most worrisome finding of the committee, in assessing the H1N1 response, was that the "world is ill prepared to respond to a severe influenza pandemic or to any similarly global, sustained and threatening public-health emergency". Indeed, data visualisations of the "next" epidemic are truly concerning. Larry Brilliant's observation that "outbreaks are inevitable, epidemics are optional" seems to apply both to pandemics and the social panic they spawn. There are rules and guidelines as to how to prepare for a pandemic and how to react and avoid panic: we ought to follow both as if our lives depended upon it.

The precarity of being indigenous: the case of Canada

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George Hunter. National Film Board of Canada. Still Photography Division. Library and Archives Canada, PA-183435.

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Canadian Prime Minister Justin Trudeau's Sept 21 speech to the UN General Assembly focused on "Canada's shame" in dealing with First Nations, Metis, and Inuit populations. Although his address drew global attention, it would have

resonated in particular with the 370 million Indigenous people around the world.

Trudeau cited the intergenerational health impact on Indigenous people of residential schools, child removals, and failure to provide basic services, describing their experience as being “mostly one of humiliation, neglect and abuse". Indeed, the recordbears him out; for example, a recent scoping review of 61 studies shows increased rates of chronic and infectious disease among school “survivors” as well as depression, anxiety, addictive behaviour, stress, and suicidal behaviour.

Trudeau was contrite and adamant that he was addressing these injustices, yet the speech itself and ensuing federal decisions in the weeks following had the opposite effect, stoking the distrust felt by Indigenous people towards government.

For example, 15 days after the speech, the Canadian Government announced that it would compensate the approximately 16,000-20,000 survivors of the so-called “sixties scoop” – the programme by which children were forcibly taken from their families and placed in non-indigenous care (in “white homes”) as far away Scotland, New Zealand, California, and Alabama (1965-84). The finding of the Ontario Superior Court - which formed the rationale for the settlement - was that Canada had breached its “duty of care” and ignored the damaging psychological effects of the programme. Although the Government lauded the compensation package (Cdn$800 million), in reality it had fought survivors’ claims “tooth and nail” in a bitter 8-year court battle. Justice Murray Sinclair, who headed up the Truth and Reconciliation Commission on residential school abuse, said it was “unconscionable” for the Government to acknowledge the genocidal aspects of the removals but then claim in court that “it had no legal obligation to prevent it”.

Another decision announced in October was by the Supreme Court of Canada (SCC) which concerned the records of 38,000 survivors of the Indian Residential Schools – narratives which described their physical, sexual, and emotional abuse. The Government had sought to retain control of these records. In a unanimous decision, the SCC sided with the survivors, stating that indigenous people should decide the fate of the records; it said that sharing the stories was meant to be a "private process" and claimants had relied on the “confidentiality assurance". According to Judges Brown and Rowe, Ottawa retaining control “is plainly not what the parties bargained for”. Reneging on this agreement with school survivors (who as children, the Government put in harm’s way in the first place) evoked long-standing resentment of school survivors against Ottawa which has over the decades repeatedly sought to hide, control, or destroy residential school records through the bureaucracies, courts, or law enforcement agencies.

Trudeau’s UN address itself raised questions of trust. His claim that the Government was a “full supporter” of the UN Declaration on the Rights of Indigenous Peoples was inconsistent with his Minister of Justice’s stated view that it is an unworkable documentand his own failure to adopt and implement the Declaration. He also claimed to have prioritized social inequalities of First Nations children when in fact he has ignored the findings of the

Canadian Human Rights Tribunal that Ottawa was discriminating against indigenous children by underfunding their health care. Recent documents reveal that Ottawa had the data that showed indigenous "children faced a massive gap in health services compared with what was available provincially". Rather than following the Tribunal's recommendations, the Government chose instead to respond through the courts, once again initiating an acrimonious legal battle.

In reality, Trudeau's UN speech is widely seen as part of a larger agenda to secure a seat on the UN Security Council. Using one agenda to advance another may suggest lack of sincerity and lack of commitment. However, in describing the needs of Canada's First Nations, Metis, and Inuit populations he evoked the UN's Sustainable Development Goals (6, 4, 5, and 11 – safe water and sanitation, education, gender equality, and sustainable communities). Trudeau will need to deliver on his promises. Early in his mandate he claimed that he inherited the distrust Indigenous people feel towards Ottawa from previous governments, yet the past months suggest that his Government earned some of this distrust itself. Taking effective steps to deliver on his promises may help address the precarity of being Indigenous in Canada and the view that federal authorities typically say one thing and mean another.

The World Bank in Kagame's Rwanda

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On August 4, 2017, Paul Kagame was re-elected President of Rwanda for a third term, winning 98% of the popular vote and extending his 17-year rule to at least 2024. Many observers are wary of these results and cite extraordinary

levels of fear and intimidation to help explain the margins. Given Rwanda's continued status as a beacon of development success, how should the international community respond?

Commentary last month by the Economist (entitled "Intimidation nation") and the Wall Street Journal (entitled "Rwanda's success story adds a dark new chapter") raised questions similar to those raised a year earlier in a Lancet Comment which acknowledged Rwanda's economic progress, yet described reports of a country of repression, violence, and torture. It noted in particular the claim that 60 journalists had been "threatened, arrested, kidnapped, beaten, assaulted, abused, imprisoned, expelled, or killed for questioning or criticising Paul Kagame and his government". The Financial Times provides the grisly details of events cited by *The Lancet*, stating that "political opponents are regularly imprisoned. Some have been killed, including those who have fled into exile".

In counterpoint, the World Bank president Kim Yong Jim in a 2-day visit to Rwanda in March 2017 (during the pre-election campaign) said "I am here to say to President Paul Kagame and the Rwandan people that the World Bank Group is ready to help in any way that they can and that we believe in the future of Rwanda and we believe that it will continue to be a model for the entire world". Jim's declaration came at a time when Diane Rwigara, an accountant and human rights activist, had undertaken a campaign to bring the Kagame government to task for abuses of civil rights and intimidation of the Rwandan people.

These differing perspectives are partly explained by the Bank's disinclination to concern itself with human rights abuses in borrowing countries. It cites its "political prohibition" from involving itself in a local politics. A report by a United Nations rapporteur assessing this policy and its consequences found that "political prohibition" is "misplaced legalism". It stated that "the World Bank is currently a human rights-free zone. In its operational policies, in particular, it treats human rights more like an infectious disease than universal values and obligations."

The Bank's recently published policy framework ignores this criticism and (according to observers) it further weakens its stance on human rights by relegating them to a non-binding "vision" statement. The framework further bolsters a value system that places primacy on results, not on the means by which they are achieved; it may open new pathways that undermine good governance or democratic institutions.

The framework also provides part of the context that enabled Jim to declare his enthusiasm that Rwanda was "a model for the entire world". This is not a shared view and the Economist states just the opposite - "many Africans see Paul Kagame's Rwanda as a model. They are wrong". Kagame's "model", it says, sends the message that "authoritarianism is more likely than democracy to bring stability and growth". The overemphasis on results rather than how they are achieved may lead to mis-steps or

unwise decisions: the fact that Jim made a 2-day visit to Rwanda in the run-up to a national election and then offered effusive support for Kagame seems inappropriate and surely ironic, given the Bank's "political prohibition". Needless to say, it was exploited by the state-controlled media.

Although Kagame once said that if he was unable to groom a successor by 2017, "it means that I have not created capacity for a post-me Rwanda. I see this as a personal failure", he in fact has methodically warded off (or eliminated) nascent threats to his power. The most recent example being Diane Rwigara, who decided at the last minute to run for President in May 2017; within days of her announcement she was demeaned on the internet and prevented from registering despite meeting the requirement set out by the electoral commission.

The international community ought to take Kagame at his word—that his presence in this month's election is an indicator of a basic failure on his part and, since it was considered a success by many donors, that it is a sign of their failure as well. It represents confusion about their stated institutional values and how far they have drifted from their mission and vision.

The naiveté of the global community to accept the astonishing margin of victory of 98% and 90% turnout is probably inversely proportional to its continuing guilt over its failure to respond to the 1994 genocide. However, the World Bank with its "political prohibition" in particular ought to take stock of what it is and where it's going—even addressing ancient questions of whether it's more interested in growth than poverty, and in disbursement than health outcomes.

Explaining Trumpcare: the appalling appeal

- 2nd Jun 2017

Photo: Tabitha Kaylee Hawk

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On May 5th 2017, the US House of Representatives voted to repeal the Affordable Care Act (Obamacare) and replace it with H.R. 1628, the American Heath Care Act (Trumpcare) by a count of 217 to 213 (all Democrats and 25 moderate

Republicans opposed the bill; all supporters were Republican).

Under Obamacare, 13 million Americans gained health insurance through marketplace programmes and another 20 million were added to insurance or expanded Medicaid role. This feat was achieved by increasing taxes of the richest 2% of the population.

A new Kaiser tracking poll (May 31st), consistent with the findings from three previous polls (a Kaiser tracking poll April 4th, Washington Post-ABC News poll April 25th, and a Politico/Harvard Poll April 25th, 2017) shows that 60-65% of the public want Obamacare left in place and improved upon. The question arises as to why Republican legislators would ignore the wishes of most citizens and risk their wrath in the 2018 mid-term elections.

Part of the answer is that on May 5th these legislators wanted to avoid dispiriting the political base by a defeat of Trumpcare; passing the bill was also seen as crucial to passing tax reform; and some legislators may have been influenced by private sector interests. For example, the Koch brothers promised millions to Republican campaigns in the mid-term if they voted to repeal Obamacare.

At another level however, the answer is more complex and is one that might help answer other important questions (such as why the US is the only industrialised nation without a universal health care system, why it has the weakest social safety net of its peers, why a large portion of the US electorate is fully prepared to act against its own best interests (rather than support beneficial distributive initiatives) and, why perhaps, Trump was elected in the first place?) These questions are relevant as some version of Trumpcare will go before the Senate in the near future. The following paragraphs look at some contributing factors.

First, recent analysis shows working class (especially white) males have felt increasingly disempowered and disenfranchised by globalisation and neoliberal policies. In the US, while the wealthy have become wealthier, the real incomes of ordinary people have stagnated or declined. Even as they became increasingly marginalised, they were expected to accept cultural values that were not theirs - for example, those related to the environment, gender and racial equality, and LGBT persons. Economic loss and cultural backlash contributed to their “rage against the machine”.

Second, Prospect Theory tells us that those who feel they have not participated in the benefits of global trends or have lost benefits may be willing to take risks in making their political choices - they feel they have nothing to lose. This theory is rooted in economics and psychology, and addresses the behavioral underpinnings of choice in the face of uncertainty. It recognises, for example, that people with poor prospects are more likely to take risks and make irrational choices by disregarding low probabilities.

Third, recent data from the Pew Research Center shows that partisan animosity has increased to record levels in the US. It is core to explaining why, for example, working class Americans continue to support Trump despite his "Cabinet of billionaires", deregulation that will hit ordinary people, and in particular, a health bill that is explicitly against their self-interests. For example, the (non-partisan) Congressional Budget Office (CBO) estimated in a May 24th report that Trumpcare would lead to an additional 23 million uninsured Americans. Partisanship (as "tribal self-expression") is a way of expressing multiple identities; party loyalty is bigger than any single policy. These identities are less about class or rich versus poor than "racial identity, professional identity, religious identity, even geographical identity". Abandoning Trump would constitute a betrayal of these tribal allegiances.

Fourth, evidence suggests that left-wing economics is not the answer to right-wing populism. Trump (and his policies such as Trumpcare) appeals directly to those who see themselves living in the "domain of losses". Yet the May 31st Kaiser Poll shows that only 15 percent of those questioned felt that Trumpcare would actually fulfill all or most of his promises – for example, "insurance for everybody". In reality, within the US support for liberal distribution policies is greatly complicated by racial and cultural identities. "People are only willing to support redistribution if they believe their tax dollars are going to people they can sympathise with. White voters, in other words, don't want to spend their tax dollars on programs that they think will benefit black or Hispanic people". A PBS documentary, "The Divided States of America" concurs and reports that the "racially charged resistance" to Obamacare came to symbolise this division in America and now Trumpcare.

These factors not only help explain the House vote to replace Obamacare with Trumpcare and set the stage for a Senate vote, but also explain the lack of a robust social safety net to protect all Americans. One week after the repeal of Obamacare in the House, conservative senators began making plans to drop millions of adults from Medicaid; indeed, the release of Trump's budget (May 23rd) reveals plans for massive cuts in the range of 25-45% over 10 years. Eight years on and perhaps eight years hence, the Trump promise is one of leading the US in circles and they seem to be part of a spiral.

Global health and Mr Trump's "new world order"

- 20th Jan 2017

Gage Skidmore

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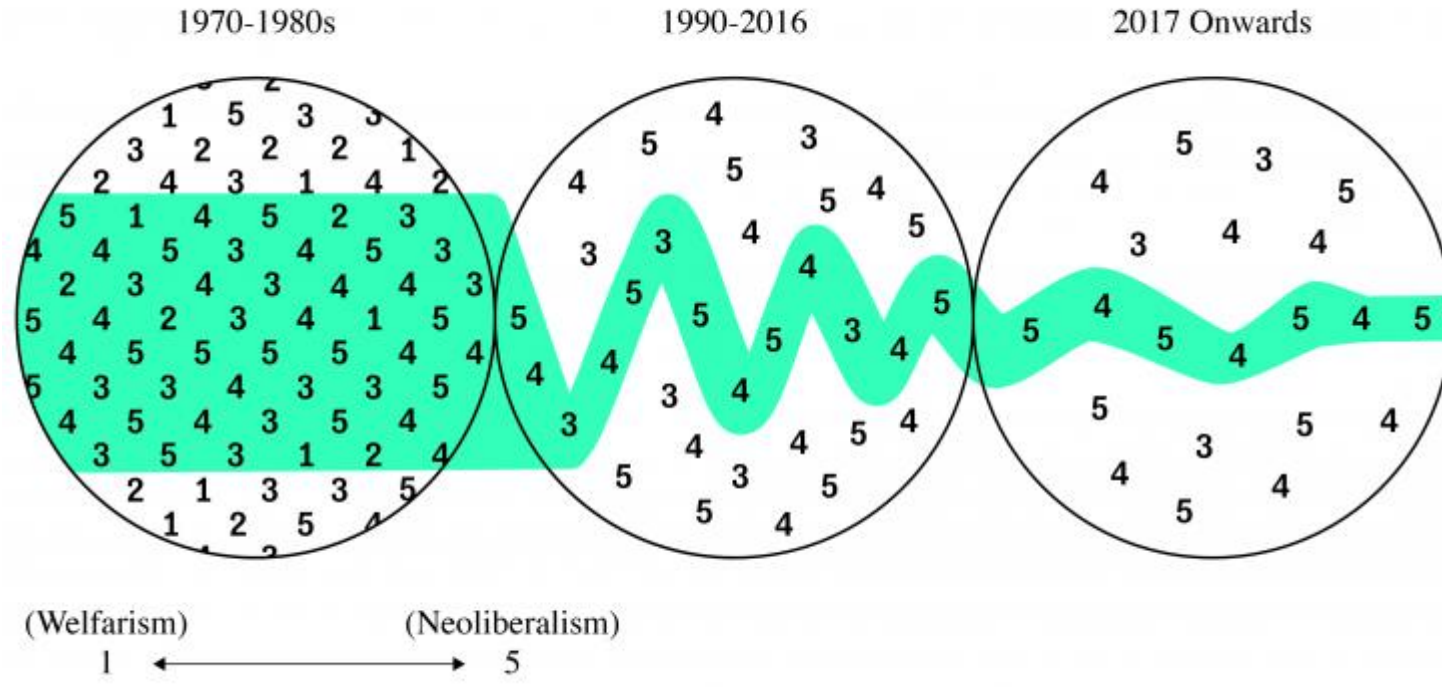
A recent study of 268 political parties in 31 European countries shows that a key factor explaining the rise in populism is the emergence of neoliberalism that began in the 1970s.(1) The Brexit vote, the election of Donald

Trump, and trends in European elections are described in multiple quarters as part of a new world order. Yet what passes for a "new world order" may in fact be no more than a continuation of the neoliberal juggernaut transiting from one era to another, to emerge stronger and more daunting than ever. Past experience suggests that this does not augur well for global health.

British Prime Minister Margaret Thatcher (1979-90) and US President Ronald Reagan (1980-88) sparked the rise of neoliberalism with their "conviction politics"; they eschewed various policy options derived from the post-war consensus and instead extolled unfettered competition and individualism. Thatcher's notion that "there is no such thing as society" captured the sentiment. Over the ensuing decades, these ideas, values, and attitudes became institutionalized and helped usher in for example, Bill Clinton's welfare reform and repeal of the Banking Act and Tony Blair's deregulation of financial institutions (1997) while simultaneously evading serious environmental legislation.
Today, deregulation is at the top of the Trump agenda (see Figure).

Figure: Trends in Neoliberalism



The impact of neoliberalism on global health has been controversial. For example, commenting on the leverage used to implement structural adjustment in poor countries, a senior World Bank economist stated "policy-based lending is where the Bank really has

power – I mean brute force. When countries really have their backs to the wall, they can be pushed into reforming things at a broad policy level that normally, in the context of policies, they can't".

An example of this is revealed by the World Bank's response to Africa's HIV crisis. The bank's own documents show how, as lead donor in Africa's health sector in the 1990s, it explicitly and repeatedly sought (and succeeded) to deprioritize AIDS in favour of its neoliberal health reform agenda. Although improvements in the way health care was financed and delivered were badly needed, HIV rates were soaring and called for immediate action. The World Bank warned that "an expanded role of the Bank in AIDS should not be allowed to overtake the critical agenda for strengthening health systems". Bank documents show that as trends emerged in the 1990s, "AIDS was even less strategically prominent in the Bank's health sector strategy" so that by 1997 a paltry US$3 was allocated for each infected African. Then, as if to underscore that the neoliberal juggernaut was oblivious to the plight of ordinary people, a World Bankreport concludes "these allocations are remarkably large relative to national spending on the same problem and probably in comparison with current international spending on any other disease. Perhaps only the international campaign to eradicate smallpox in the 1970s benefited from such a large preponderance of donor funds." By the end of the decade 30 million Africans were dead or dying.

Two financial crises exemplify deregulation's impact on the wellbeing of ordinary people. The East Asian Financial Crisis (1997-98) and the Great Recession (2008) became bookends for a spate of aggressive deregulation initiatives taken over a 10 year period. In East Asia, the free-flow of capital and poorly regulated banks eventually led to taxpayers footing the bill to "right the ship". In Indonesia for example, the International Monetary Fund (IMF) "persuaded" governments to cut spending in order to repay western banks, leading to a 25% cut in primary health-care spending, a decline of between 26% and 47% in the uptake of services such as clinics and health centres (used mainly by the poor), and a 25% fall in the percentage of children vaccinated. After decades of steady improvement in life expectancy, infant mortality increased in 22 of 26 provinces by an average of 14% between 1996 and 1999. The tragedy was worsened by the international financial institutions' failure to select the best data available to describe health outcomes – choosing data that instead painted a rosier picture.

Indeed, a key feature of this rise of neoliberalism is the tendency to ignore or deny unwanted data or to cherry pick for those that suit the purpose - the so-called "post-truth". For example, American government scientists are reported to be frantically copying climate data for fear they may be destroyed after Barack Obama leaves office - prompted perhaps by the nomination of the CEO of Exxon Mobile to head-up the State Department. This, the world's largest oil company, is under investigation by 17 attorneys general in the USA for allegedly suppressing data on the risks of climate change. Other data that are being ignored by Trump and all his cabinet nominees are those that show that the percentage of Americans uninsured is now at historic lows. Under the Affordable Care Act, 13 million Americans now have health insurance through marketplace programmes and

another 20 million have been added to insurance or expanded Medicaid role. The stated goals of the incoming government is to “repeal and replace” Obamacare.

The Figure shows neoliberalism’s trajectory becoming more linear and focused and, perhaps, benefiting increasingly fewer. Indeed, the rising levels of inequalities since the 1970s, once framed in terms of the elite 10%, are now often cited as the top 1% or even the world’s 2500 billionaires. Many observers have noted that, despite Trump’s railing against Wall Street and elites, his nominees are now described as the “cabinet of billionaires”. Their wealth is estimated at US$14 billion - that is, 50 times greater than that of George W Bush’s cabinet. If this is a “new global order”, it is one marked by irony. The rise of “unfettered competition and individualism” and dramatic unravelling of regulations are a threat to the values and ideals of local and global health and to the wellbeing of many of those who supported Trump. For example Steven Mnuchin, the nominee for Secretary of the Treasury (which plays a dominant role in World Bank and IMF lending), a banker at the center of thousands of foreclosures of subprime mortgages, said his main focus is “making sure we scale back regulation”. A former bank executive noted that Mnuchin “is an ideal emissary of Wall Street”; in contrast, a retiree who voted for Trump, said upon learning of the nomination: “they all promise you the world at the end of a stick and take it away once they get in."

At a time normally marked by a sense of hope and renewal, much of the global community feels uncertain and, in many quarters, trepidation about what lies ahead. A four-page memo circulated by Trump’s transition team to the State Department and reported in the New York Times this past week indicates an overall scepticism about foreign aid and humanitarian assistance and depicts a sharper focus on US business interests. It asks, for example, “Why should we spend these funds on Africa when we are suffering here in the U.S.?” If the answers to this and related questions are unknown, then the next 4 years may indeed give new meaning to neoliberalism and perhaps conviction politics – both at home and abroad.

The rise of walls and the decline of values: from Trump to Calais

- 3rd Nov 2016

Dave Pinter

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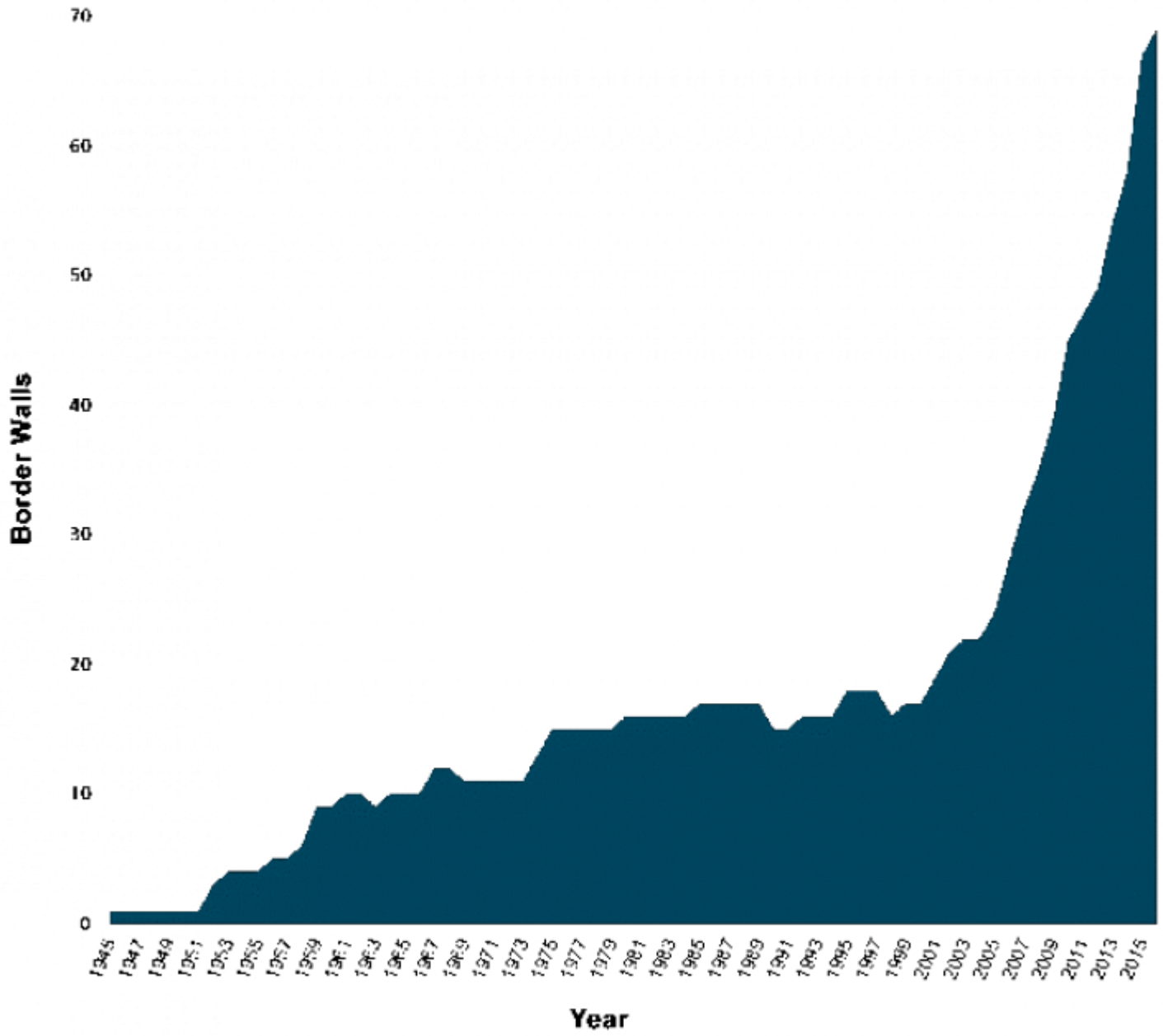
Breaking down walls, removing barriers, and opening pathways for cooperation and collaboration have long been at the core of international and global health—at least conceptually. Resistance to these goals and their

underlying values has typically been ideologically or economically driven, reflecting the self-interest of powerful actors. However, the obstructions these actors create have never been as conspicuous, widespread, symbolic, or impactful as they are today.

The figure shows the number of walls and fences erected on national borders during the period 1945-2015. It depicts a modest increase from 1945 until 1989 when the Berlin Wall came down and then shows a sharp rise, especially over the last 15 years. Many of the nearly 70 walls have been built recently in Europe where countries are attempting to cope with a profound immigration crisis in which millions of people are on the move. Interestingly, the graphic representation of these trends actually conjures up the image of a bolstered wall.



Source: Update by Élisabeth Vallet, Zoé Barry, and Josselyn Guillarmou of statistics included in Élisabeth Vallet, ed., Borders, Fences and Walls: State of Insecurity? (Farnham, UK: Ashgate Publishing, 2014).

The refugee crisis in Europe, the building of the wall in Calais, the dismantlement of the so-called "jungle" refugee camp, and the plight of its children have drawn global attention. Walls have become a metaphor for fear and resentment and for the overarching paradox that, while the global community is more interconnected than ever, it is becoming increasingly fragmented.

A particularly disturbing aspect of these trends is the anti-migrant, anti-Muslim, anti-ethnic rhetoric that accompanies them. This is perhaps epitomized in the speeches of Donald

Trump (Republican nominee in the US presidential elections to be held November 8). A video shows Trump exhorting thousands of supporters with a refrain—"build that wall, build that wall"—evocative of scenes from the darkest days of 20th century Europe.

The plight of migrants and chaos along national borders appearing daily in the media is in sharp contrast to the vision and values of international and global health as originally conceived. For instance, Halfdan Mahler, Director-General of WHO during 1973-88 and who ushered in the Declaration of Alma Alta (1978) on primary health care (PHC), described the 1970s as a "warm decade of social justice". PHC envisioned removal of the barriers between health facility and the populations it served by focusing on simple and inexpensive interventions at the village level (essentially patient- or family-centred care).

For Igogwe Hospital, a 100-bed facility in the southern highlands of Tanzania, the adoption of PHC in the 1980s literally meant the removal barriers from the hospital compound and sending health workers out into the villages where they developed and strengthened a network of rural health centres, maternal and child health clinics, and mobile services. When HIV/AIDS hit hard, Igogwe had a range of initiatives a full 10 years before the international donor community.

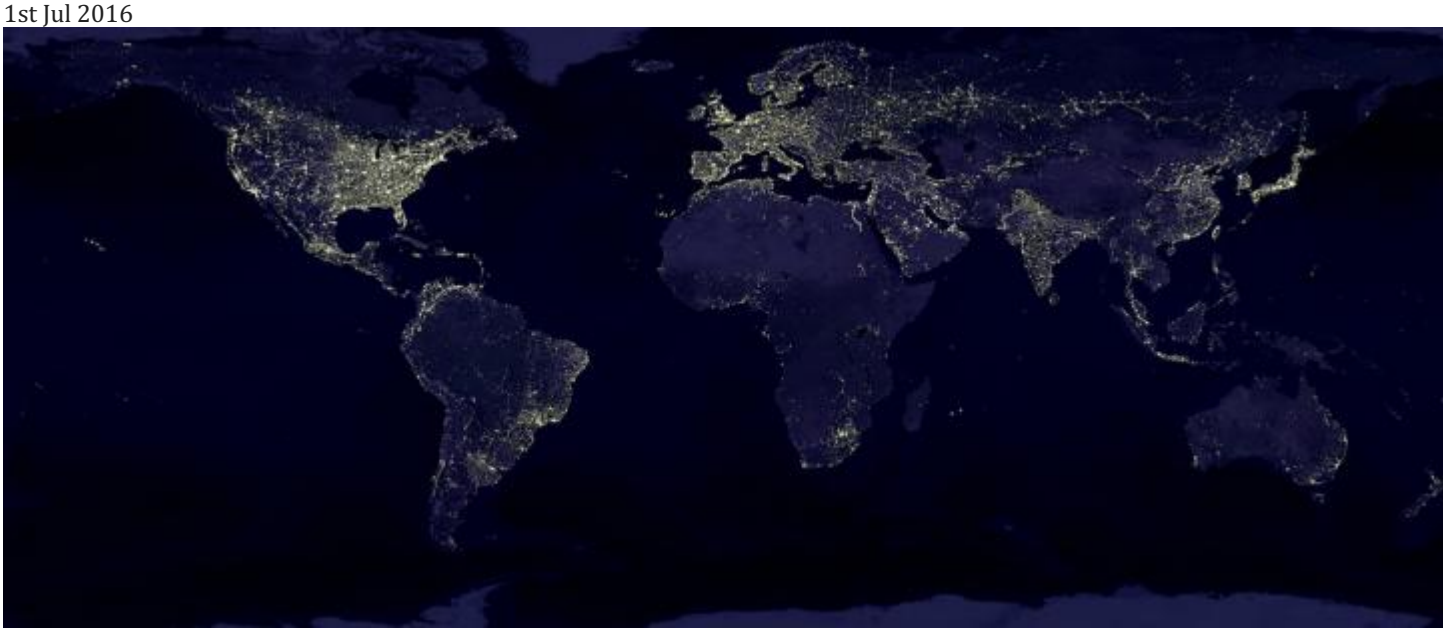
Yet rural hospitals like Igogwe were the exception. Halfdan Mahler, recalls that when the International Monetary Fund and World Bank interposed their policies of structural adjustment and health reform, they created barriers to access as real as bricks and mortar. For the world's poorest, the 1990s became known as the lost decade.

The Consortium of Universities for Global Health distinguishes global health from international health, stating that the former refers to "the scope of problems, not their location", that it parallels a shift "in philosophy and attitude that stresses the mutuality of real partnership", and aims for "health equity among nations and for all peoples"—that is, a more level playing field without barriers. While most donor countries embrace these values (including the European Union), it is typically left to the non-governmental organization community which, together with its southern partners, works with ordinary people, their families, and communities to address the detrimental impact of walls along borders. For example, Christian Aid issued "Breaking down the barriers", Action Aid, "Protect people, not borders", while Doctors without Borders' vision and mission are self-evident.

Walls are often used as metaphor for the way they separate, for those they keep out or keep in, for the way they are built (perhaps representing the gradual accumulation of resentment) or suddenly rise up (flare-up) overnight, for the way they frighten, cause despair, or obstruct our view of deeper problems. Some of these metaphorical allusions ought to resonate with the global community. From a health systems point of view (or from a Donabedian analysis perspective) a wall—in that it exists at all—tends to imply inadequate inputs, poor process, poor outcomes, and generally mass failure – a scar on the global landscape. In his final address to the UN in September, US President Barack Obama stated that these walls paradoxically imprisoned those who build them.

Global risks and consilience: mapping a way forward

- 1st Jul 2016



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Along with good intentions, fear and anxiety pervade the agendas of recent world community gatherings such as the World Humanitarian Summit that took place in May 2016, the High-Level Signing Ceremony of the Paris Agreement

on Climate Change in April of the same year, the High Level Conference on Global Health Security in March 2016, and the World Economic Forum in January. World leaders as well as ordinary people are increasingly worried about rising numbers of catastrophic events, including those related to climate change, migration, global health security, and social instability.

Concurrently, there is a broadening and deepening of public awareness of conspicuous inequalities, plummeting social trust, and failure by the global community to mitigate and adapt to risks even as they cascade into one another. Over the last two decades, the global community has sought to address risk, for example, by reducing relative and absolute poverty. The evolution of international health into global health, and its introduction into foreign affairs, diplomacy and international relations are part of this trend.

However, with global warming, terrorism and migration now at the fore, other efforts to understand and deal with new and existing risks have emerged. For example, public and private sectors (as well as academics) are turning to so-called superforecasters to predict near-term social and political events. With a record of consistently outperforming the experts, superforecasters use statistics and systematic analysis to synthesize material from diverse fields of investigation; although they make predictions with precision, they keep an open mind and are prepared to adjust and readjust their predictions as they learn from mistakes and take into account new data. Other efforts have built on research into social networks (which suggest that we are led by people around us) that may help predict major events such as epidemics. Elsewhere, there is a focus on connectography which claims that connectivity not geography will map out destiny and integration and globality will be our new morality.

Another means of understanding anxiety-producing global risk is by looking at historical events and the maps that described them. For example, the public health and epidemiological factors underlying the Black Death in 14th Century England that killed more than one third of the population are today well understood. Recent research and mapping of the epidemic reveal a country living "in constant fear of God's wrath and the end of the world". This is captured in what today might pass for a blog post or a tweet: scratched into the stone of St. Mary's Church (north wall of the nave) in Ashwell, Hertfordshire in 1361 is the following -"There was a plague 1000, three times 100, five times 10, a pitiable, fierce violent [plague departed]; a wretched populace survives".

In contrast, when cholera hit a district of London known as "the Golden Square" centuries on (1854), it elicited a different response; this time maps were not drawn retrospectively by historians but rather by a local physician, Dr. John Snow. He is described as a consilient thinker, that is, he drew on different disciplines (including bacteriology, medicine, statistics and what would be, epidemiology) to plot out cholera cases and a map of the epidemic.

With the help of a clergyman who provided local knowledge he identified the neighbourhood water pump as the source of the outbreak and then acted as an advocate to persuade authorities to close the pump, thus endingthe epidemic.

This notion of consilience (a term resurrected by E. O. Wilson) is discernible in the Global Risk Report's interconnected maps, global health (as defined by the Consortiumof Universities for Global Health), superforecasting, and connectography all of which draw on many disciplines. Global health bolsters its consilient profile by drawing on knowledge and experience from developed and developing countries, by using quantitative, qualitative, perception data (from ordinary people as well as specialists) and, by stressing partnerships and collaboration to bring these worlds together. If "consilience" evokes the notion of reform of global learning in order to tackle global risk, it is relevant to this discussion.

However, despite E.O. Wilson's "noble and unifying vision" of consilience and its embrace by parts of the global community, the community itself is not unified. Many observers are disconcerted by the great divide between the development and humanitarian communities as well as between the global health and humanitarian communities. For example, the scheduling conflict between the World Humanitarian Summit and the World Health Assembly (in May 2016), and the notable absence from the Summit of high-level support, Ministers of Health and other stakeholders seem to underscore this divide – one which makes any significant decisions less likely, especially as they relate to resource allocation – leaving ordinary people vulnerable to catastrophic events still vulnerable.

In a recent BBC interview, Peter Piot reached back 20 years ago to when, as Executive Director of UNAIDS, he witnessed up-close a fractured global community as it sought to deny antiretroviral therapy (ARVs) to Africans – when the science and opportunity existed to save lives. He was surprised and angered by this ignoble undertaking. Yet it's unclear how much has changed over the last two decades. Despite the science and mapped predictions, the global community has failed to deal effectively with climate change. With consilience as a backdrop, perhaps the way forward is to examine the fracture itself and the handful of stakeholders that direct it through opaque negotiations and decisions typically unmoved by science, peers, or victims. In the meantime, it appears that the global community has not yet the capacity to deal with the overarching paradox – that while we are more hyperconnected than ever, we are increasingly fractured.

Undoing the undoing of Canada as global health citizen

- 26th Feb 2016

Province of British Columbia

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When Canada's new Prime Minister, Justin Trudeau addressed the World Economic Forum (WEF) at Davos last month, restoring trust in Canada as a global citizen was at the top of his agenda. The previous government's 10-year

record of “multilateralism as a weak-nation policy” and the just-released WEF 2016 Global Risk Report helped provide the encouragement needed to change the policies that were the previous administration’s downfall.

Former conservative Prime Minister Stephen Harper (2006-2015) made resource development the centerpiece of his administration without fully taking into account its environmental impact, aboriginal rights, scientific evidence or the opinion of the global community. While Canada’s reputation as global citizen declined internationally, democratic values and social trust were threatened domestically by a clamp-down on legitimate and peaceful protest, access to government information, the muzzling of government scientists and intimidation of civil society groups – most notably by agencies meant to enforce the law.

As to the troubling WEB Report (reflecting the opinion of more than 750 experts), it warned that global threats (such as catastrophic climate events, large-scale involuntary migration and global health insecurity) are now more interconnected, more likely, more impactful, and more imminent than ever before. For the global community, creating trust within and between nations is seen by WEF as the main challenge and solution to global risks

Mr. Trudeau seems committed to building trust. He promised open and accountablegovernment, close cooperation with the global community, re-engagement with the United Nations and multilateral institutions and, a policy of inclusivity and diversity. Having already chosen for his cabinet of 30 ministers, 15 women and 2 aboriginals, he was inclined to cite “diversity” 12 times in his Davos speech – describing it as a source of strength and resilience for Canada.

Detailed and transparent (online) mandate letters to each cabinet member on what is to be done and how have led to a cascade of policy changes directed at reversing the Harper legacy - , many coming into immediate effect, most notably in the area of public health. For example, to restore the flow of information expected of a pluralistic, democratic society, Canada’s 6000 federal scientists have been de-muzzled allowing them to share their findings on the health and safety of Canadians as they see fit; the long-form census, an important source of data on vulnerable groups has been reinstated. As to information from civil society to government - the Canadian Revenue Agency was ordered to end its harassment of environmental NGOs critical of the oil sands and the Minister of Justice has been instructed to amend controversial Bill 51 that portrays environmentalists and First Nations activists as terrorists.

A fundamental resetting of relations with First Nations, the indigenous Canadian population, has begun under Mr. Trudeau. Action on long-ignored inequalities is promised including robust social sector investment, full implementation of the 94 Truth and Reconciliation Commission recommendations (meant to deal with the on-going suffering

associated with the Indian Residential System); a national inquiry into "murdered and missing aboriginal women and girls"; and the immediate end of long-term solitary confinement in federal prisons (that affects mainly aboriginals). This shift in tone has perhaps emboldened other agencies: the Human Rights Commissioner has now ruled that the federal government indeed discriminates against aboriginal women and children in providing health care and; the Commissioner of the Royal Canadian Mounted Police (RCMP), an institution that First Nations deeply distrust, has acknowledged on national television that racism exits within its ranks and promised to rectify it.

An unshackled Department of Foreign Affairs has swiftly reversed a policy known as "sovereign self-interest" that saw trade and commerce suborn human rights, international development and humanitarian assistance. For example, 50,000 Syrian refugees have been welcomed to Canada (25,000 by the end of February 2016); aid for maternal, newborn and child health has been refocused to include reproductive rights. Commitments made at the Paris Climate Talks have led to actions at home: strengthening of the oil and gas to include upstream greenhouse emissions. Perhaps emboldened as well, the Commissioner of the Environment reported that audit of the National Energy Board (NEB) shows it failed to track compliance by pipeline industry and that nearly half requested files were missing or outdated.

Although these policies suggest good governance begets good governance, they are drawn from a diminishing supply of "low-hanging fruit" and subject to the criticism of being reactive, linked more to campaign promises than an overall plan; they represent practically and conceptually a fraction of what is needed to confront an increasingly complex and dangerous world. Perhaps acknowledging this, superforecasting expertise has been introduced into Prime Minister's Office to help guide decision-making. Yet what is more obviously needed (and more transparent) is a global health strategy to help set priorities, guide choices, and create efficiency and cooperation; the very process of developing such a framework would help identify local and global partners and how they measure success. In contrast to recent years where such a strategy would have exposed abject failure, it would highlight and enhance efforts to confront global risks through trust and partnerships.

Human rights at the World Bank: inside out

- 1st Dec 2015

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Few organisations know more about human rights, inequalities, and diversity than the World Bank; indeed, its website and e-library are replete with information on how each of these relate to the health and wellbeing of

individuals and populations. Yet a recent report from the UN Special Rapporteur on Human Rights adds to claims that, internally and externally, the bank does not practise what it preaches and that it often seems incapable of learning from past failures.

The report states that the Bank ignores human rights and treats them "more like a disease than universal values and obligations"; operationally its approach is "incoherent, counterproductive and unsustainable".

Jim Yong Kim addressed the issue earlier this year, blaming the "political prohibition"clause that prevents it from involving itself in the political affairs and thus the human rights of any country. However, the UN rapporteur calls this "misplaced legalism" and says that, together with institutional culture, a lack of transparency, and a host of other factors, the Bank's response on human rights is anachronistic and, for most purposes, the institution "is a human rights-free zone".

Interestingly, these same factors also help explain the Bank's failure to address internal human rights abuses. Especially striking is the lack of response to studies (many undertaken by the Bank itself) showing a culture of systemic discrimination against African-Americans at senior bank levels. Again, because of a legalism, the Bank (as a UN agency headquartered in the USA) is not required to collect race-based data nor provide independent arms-length assessment of claims of discrimination—so it does neither. A recently released survey taken by 10,000 Bank employees shows that (among other important findings) only 43% of respondents said managers are held to account when actions or behaviour are contrary to the institution's values on diversity and inclusion.

A Way Forward

To close the gap between knowing and doing, Bank leadership ought to listen to the independent evaluators whose advice it seeks and for which it pays. Their reports describe worsening trends in performance, mainly driven by poor quality of work before implementation—ie, not "getting things right from the outset". Special attention is drawn to poor risk assessment and risk management. Indeed, recent investigations into Bank projects reveal a doubling of projects graded highest risk for "irreversible or unprecedented" social or environmental impacts and that, over the last 10 years, "projects funded by the World Bank have physically or economically displaced an estimated 3.4 million people".

The UN report says the Bank is reducing the probability of success by delinking what is inextricably linked—health and human rights. It says human rights need to be integrated from the outset and that therefore the Bank should adopt an approach that is above all "principled, compelling and transparent", making use of "the universally accepted human rights framework".

Similarly, diversity frameworks commonly used in the public and private sectors are acknowledged to lead to better process and outcomes. The Bank might take into account two key functions performed by its neighbour in Washington, DC—the Equal Employment Opportunity Commission (EEOC) which enforces discrimination in employment laws in the USA. First, it requires businesses to report their diversity data; second, it provides independent assessment of claims of discrimination. Critics claimthat the Bank's internal Administrative Tribunal (whose members work for the Bank) has yet to find a single case of discrimination against African-Americans.

Calls for the Bank to address human rights come at a time when its leadership and strategic direction are in question by two-thirds of its employees. At issue are reform efforts: first to shift from a country-centred structure to one that is sector-based, and second to create knowledge-based departments. Critics worry that the sector-wide approach will reduce human rights social safeguards by placing the onus to protect them on country governments, which may not have the required resources or inclination to do so. The goal to become a "knowledge-based organization" seems improbable since, by its own account, it has yet to become a "learning organization"—one that sees learning more than an "optional extra".

There is a disquieting symmetry between discrimination in the executive suites at World Bank headquarters in downtown Washington and human rights abuses in the field that affect millions—both the consequence of "misplaced legalism". It is also worrisome that only 26% of Bank staff believes they work in climate of "openness and trust"; worrisome too is Kim's observation that "I've done this before in other organizations and what I've found is that if you know a change has to be made, just do it as quickly as you can, and get it done". None of this is indicative of a learning organisation, one that is going to close to the gap between what it practises and what it preaches, one that will lead by example. The UN rapporteur is right—what is needed is transparent dialogue that will generate an "informed and nuanced policy" on human rights.

Aboriginal health and the rise of racism in Canada

- 13th Apr 2015

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Are Canada's 1.3 million Aboriginal people being deliberately or inadvertently discriminated against by a government overly concerned about its resource development strategy? However counter-intuitive the

question is of a nation widely seen as tolerant (and that ranks 7th of 132 countries on the Social Progress Index), it's being asked by Aboriginal people wary of more policies that exclude and control.

Recent studies show a rise in discrimination against Aboriginal people such that Canada may have a worse race problem than the USA; racism pervades the health system and is highly correlated with poor outcomes. Indeed, astonishing public health images of First Nations communities confirm health outcomes on par with many poorer countries, worsened by epidemic levels of depressive and behavioral disorders. These are associated with the intergeneration impact of an abusive assimilation program known as the Indian Residential School (IRS) system (1880-1996) in which 150,000 children were taken from their families and forced to attend ten months of every year.

In 2006, new reasons for discrimination emerged. A newly elected Conservative government launched a $600 billion development plan for the oil, gas, mining, and pipeline industries with many of its initiatives on, or near, aboriginal traditional lands. In a departure from the past, aboriginals began to fight back with increasing success by accessing the courts, holding public demonstrations and forming alliances with non-Aboriginal interest groups.

Government responses to First Nations' initiatives have been swift and harsh. Carried out by a worrisome combination of those who make the laws and those that enforce them, this approach portrays Aboriginal people as the main barrier to Canada's resource development and its future prosperity. Especially striking is that these responses constitute the opposite of common discrimination-reducing strategies - tackling inequalities, increasing public information, building coalitions, and collective action - and therefore seem systematic and purposive.

Four strategies thwarted

One means of marginalizing (and promoting racist views) is "victim-blaming", that is, making victims appear responsible for the circumstances in which they find themselves. The federal government has managed information so that data that would help explain antisocial behavior and disparities are repressed while data that bolster the stereotype(violence, alcohol abuse and so forth) are left to flourish. For example, Prime Minister Stephen Harper's government has fought hard to withhold IRS documents showing government-sponsored medical and nutritional experiments on the children, the use of electric shocks on the recalcitrant, and an astonishing 3,000 onsite child deaths at the residential schools. Despite pleadings from First Nations leadership, Canadian Archivistsand the Commissioner of Truth and Reconciliation Commission (TRC), the government has stymied full access to IRS documents; when 40,000 IRS abuse victims finally gave recorded testimony to the TRC, the government turned to the Courts for permission to destroy this very evidence.

Similarly, pleadings by Canadian and international scientists for data on existing and new disparities (particularly those related to the oil sands) have been ignored by the Harper government. As to inequalities themselves and the notion of creating a more level playing field, the government has been stone-faced, responding instead by cancellinga 5 billion dollar Federal Accord and, over recent years, cutting most Aboriginal-led health programming meant to address the sequelae of the IRS.

Another discrimination-reducing strategy, extension of group boundaries, was embraced by First Nations who began to form high-profile alliances with a host of well-respected environmental non-governmental organizations (NGOs). Among its responses, the government publically engaged the Canada Revenue Agency (CRA) to conduct extensive audits on their records based on the notion that they were too political. The Minister of Finance unabashedly warned, that if he were one of these groups "I would be cautious". What he did not say was that the CRA - which will launch an investigation in response to public complaints - received formal filings from Ethical Oil (an online activists group working in defense of the oil-sands development) whose founder, is currently the director of issues management in the Prime Minister's Office.

Aboriginals also took collective action as an obvious discrimination-reducing option. The First Nations and Family Caring Society (headed by Cindy Blackstock), filed legal claims against the government for failing to provide adequate healthcare to Aboriginal children; the government had the Royal Canadian Mounted Police (RCMP) and Canadian Security Intelligence Service (CSIS) place her under surveillance, gathering a 400 page file on her in the process. The Federal Privacy Commissioner condemned these actions, ordered the agencies to cease and desist and destroy the files. Similarly, reportsreleased this month show that these two agencies are proactively monitoring aboriginal peaceful protest groups in expectation of demonstrations against resource extraction projects.

Indeed, critics are questioning the professionalism, non-partisanship and closeness of these agencies to industry that is so detrimental to aboriginal well-being. They ask of CSIS "why are they producing these intelligence reports on protest activity they acknowledge is legitimate and outside their mandate"? Revelations of a 44 page RCMP memo this month identifying Aboriginal protesters as the political fringe while extoling the virtues and inevitability of the oil sands and repeatedly casting doubt on global warming. Past revelations that these agencies are sharing information with industry and that the watchdog overseeing them was led by industry lobbyists lend credence to these worries.

An evolving polity points the way forward

As to a way forward, the government may wish to take a step back now that the oil market has partially collapsed, towards a more balanced and less frenetic approach to economic development. The polity is evolving. While ordinary Canadians may not yet perceive the plight of Aboriginal people as a top priority, they are nonetheless uncomfortable with the persistence of the Indian Act of 1886 (the only race-based legislation in a Western democracy), the requirement that Aboriginal people have an identity card and their

disenfranchisement by the so-called Fair Elections Act (having only gained the vote in 1960). They are embarrassed by the quality of public discourse: by Mr. Harper's assertion to the G20 that "Every nation wants to be Canada…We also have no history of colonialism"; by a former acting Minister for Indian and Northern Affairs claim that it isn't the government's job to make sure children have full bellies - then asking "Is it my job to feed my neighbour's child? I don't think so". In contrast, provincial and territorial governments have signaled a desire to tackle at least some of the inequalities related to First Nations grievances. The courts have increasingly handed First Nations victories related to resource development, suggesting consultation and dialogue are the way forward for the federal government. It ought to realign its strategic planning and management with core Canadian values; better lean than mean.

An overlooked WWI legacy: maternal and child health in sub-Saharan Africa

- 11th Nov 2014

Wellcome Library, London

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An important legacy of World War I was the rise of maternal and child health care in many European centres; a related yet overlooked legacy is the simultaneous

transfer of these services to their colonial possessions during the years of conflict and those immediately following.

In England, the surge of maternal and child health care was prompted by humanitarianism and concerns about the loss of lives, plummeting birth rates, a depleted workforce, and the ability of the Empire to defend itself. Women's groups, medical associations, religious charities, and other parts of civil society contributed to the development of services. The provision of antenatal care, delivery assistance at birth, and health education in the areas of hygiene and nutrition - together with a better standard of living - led to improved health outcomes: infant mortality rates which declined by 7% from 1905 to 1913 fell by 20% during the period 1914-18. In some industrialised centres with little evidence of wage increases or water and sanitation improvements, infant mortality rates still fell significantly; in Wigan, England, it declined from 179 deaths to 117 (per 1000 livebirths) between 1913 and 1919.

Colonial administrators expressed similar concerns in sub-Saharan Africa during the war years about very high levels of infant mortality and the viability of the local workforce. The Imperialist rhetoric at the time was to introduce "modern and civilizing ideas" to the colonial possessions; the introduction of maternal and infant health in particular, "was designed to improve the colonial labor supply, pacify indigenous populations and promote modernization". The rise of humanitarianism and volunteerism seen in England spilled over into the colonies through volunteerism and provided the means to deliver maternal and child health services to Africans, mainly by medical missionaries.

Although reliable household survey data show that maternal and child health care has a large impact on childhood mortality (which is typically 50-100% higher for women who receive no antenatal care or delivery assistance at birth than for women who receive both) and medical missions provided 25-50% of maternal and child health care in sub-Saharan Africa throughout most of the 20th century, "little scholarship addresses their influence on African health care and health status" and a vast mission archive remains almost completely unexplored. This neglect is partially explained by the justifiable view that traditional missionaries (as distinct from the new breed of independent evangelists) were a colonial construct used to justify the actions of imperialist powers, and generally an embarrassment to academics.

Yet from the medical or public health point of view, evidence from Tanzania, Zambia, and many other parts of sub-Saharan Africa would suggest that traditional medical missions have been professionally staffed and managed - at least since the 1960s independence era. Indeed, studies suggest that, rather than being a source of embarrassment, medical missions have shown what can be achieved when health initiatives are planned and implemented as if ordinary people mattered. Delivered mainly by women working at the grassroots level, often incorporating local knowledge and sometimes reproducing "aspects of indigenous models of the healer", they provided, in essence, family-centred health care.

Furthermore, medical missions often protected the communities they served from some of the most egregious policies implemented by the international community. For example, over the past 30 years or so—an era of deregulation, free flow of capital, and proliferation of other neoliberal policies—the IFIs and donor aid agencies (by their own account) implemented adjustment operations and health-sector reforms without paying attention to their impact on the most vulnerable. Their austerity measures typically led to a 50% cut in health-care expenditures in sub-Saharan Africa, a collapse of health-care systems, and a reversal of child survival trends.

In Zambia, where maternal and child health care fell into disarray and infant mortality rates skyrocketed, the World Bank (without a trace of irony) reported that "the people have nowhere to turn for help. Those (rural) buildings which have been historically PHC centers or district hospitals are empty shells. Many institutions are losing qualified health personnel, are utterly devoid of basic health materials". Yet in districts where medical missionaries delivered basic services to Zambians, quality and access by the poor were generally maintained by staying focused on the careful allocation of scarce resources to cost-effective care that targeted the most vulnerable. Although their catchment areas were more geographically remote, had higher levels of poverty and childhood malnutrition, more female-headed households, less food security, and were more vulnerable to drought, they provided 75% more assisted deliveries per head than non-mission districts and had childhood mortality rates that were 12% lower. In fact, so striking were the differences that statistical analysis of district data showed that neither poverty nor malnutrition but rather access to maternal and child health services explained variation in child survival.

As HIV gripped Africa in the 1990s, mission health facilities with strong community care networks were well placed to tackle the crisis at the local and household level and typically responded a full 10-12 years before the international donor community and national governments took substantive action. By 1988, mission facilities in Mbeya, Tanzania, for instance, had already launched robust programming that included a sweeping condom distribution initiative, voluntary counselling and testing, community education programming, home-support programmes, and eventually prevention of mother-to-child transmission programmes. In contrast, the World Bank, the lead donor in Africa's health sector, repeatedly eschewed involvement in the pandemic in favour of its health reform package. It warned in 1992 that, "an expanded role of the Bank in AIDS should not be allowed to overtake the critical agenda for strengthening health systems". It was only by 2000 that the donor community began to invest in the prevention and control of HIV, by which time 30 million Africans were dead or dying.

Negative sentiments towards missionaries have been bolstered in recent years by some Christian fundamentalists who have sought abstinence-only approaches to HIV prevention and by the appalling rhetoric of mission fringe groups that has encouraged the criminalisation of homosexuality in parts of sub-Saharan Africa - neither of which have a bearing on the traditional medical missionaries under discussion. The risk, however, of dismissing missionaries as an embarrassment, too "intimately tied up with colonialism and exploitation" is that a one-sided view of events persists unchallenged (that of the

military and bureaucracy); it means missing the opportunity to obtain a bottom-up view of colonial and post-colonial history, one that incorporates the voice of ordinary people (the so-called subalterns). Ironically this is the type of information that most national aid agencies now insist on when taking a "livelihoods approach" to development.

It also implies that lessons-to-be-learned are neither identified, nor acted upon, and that past mistakes will be repeated. For some, of course, failure to design and implement development strategies as if ordinary people mattered would help explain repeated policy miscues and the rise in inequalities in sub-Saharan Africa over the past 30 years. The simultaneous rise of maternal and child health care in sub-Saharan Africa and England is interesting because both were driven by the practical and the altruistic – a good combination when enduring social policy is the objective.